BOUNDARY Community Hospital

INJURED AT WORK?
WORKER'S COMPENSATION PROCESS

1. Report injury immediately to your Supervisor, Shift Lead, or House Supervisor.
2. Proceed to the Occupational Health/Emergency Department to complete the mandatory drug/alcohol test immediately after the injury occurs.
3. Complete the **Employee Injury or Illness Report** form.
    a. Our policy states the paper work must be done within 24 hours of the event.
    b. Turn it into your Supervisor for review.
    c. This form should be completed regardless if you seek medical care or not.
4. If your injury requires non-emergent medical care:
    a. Schedule an appointment to be seen by our Workers Compensation Provider at Boundary Community Rural Health Clinic at 208-267-3655 or #4401. Please mention you are a BCH employee calling regarding a work-related injury.
5. If your injury requires emergent care:
    a. Emergent care will most likely be the exception not the norm.
    b. Example of emergent care are: heart attack, stroke, broken bones, loss of consciousness, profuse bleeding, needle stick, blood or body fluid exposure.
    c. ER Doctor will refer you back to BCH clinic once emergent care is given.
6. If you require medication take the First Fill Pharmacy form to your pharmacy.
    a. Download at BHC Intranet /Human Resources /Workers comp. This will allow you to fill a prescription prior to receiving your Workers comp claim number.
7. The Medical Provider will need to complete the **BCH Medical Release** form listing any work restrictions. Please use the form located on our intranet.
    a. Light Duty is offered to all work related injury/illness regardless of limitations.
8. If you seek medical care a representative from our Worker's Compensation Insurance Co. Idaho State Insurance Fund (SIF) will contact you about your claim.
    a. Please cooperate with their request for medical information as this will expedite your claim.
9. Your supervisor will meet with you to investigate the illness/injury and discuss light duty.
    a. The **Supervisor's Accident Investigation for Employee** will be completed at this time.
10. BOTH the Employee Injury or Illness Report form AND the Supervisor's Accident Investigation for Employee need to be forwarded to Human Resources within 24 hours of injury.

Contact Human Resources with any questions about the process.

Example: Non-emergent medical care

A CNA strains their lower back assisting a resident/patient and is experiencing pain. They cannot work the remainder of their shift. What should they do?

1. Fill out the Report of Injury/Illness form and give to supervisor.
2. Go to the ED department for the Drug/alcohol test.
3. Employee returns to work if able, or goes home to care for their back.
4. If the injury requires medical care, schedule an appointment with our Workers Compensation Provider at **BCH Rural Health Clinic at 208-267-3655 or #4401** (typically within 24 hrs).

Example: No medical care required

An employee cuts their finger and only needs a band aid.

1. Fill out the Report of Injury/Illness form and give to supervisor
2. Go to the Emergency Department and take a Drug/Alcohol Test.
3. Basic first aid is performed so you will not need to be seen by a Medical Provider.

Example: Emergent medical care

A RN is poked by a sharp while cleaning up ED Room 3.

1. Fill out the Report of Injury/Illness form and give to supervisor
2. Go to the Emergency Department and take a Drug/Alcohol Test.
3. Be seen by Medical Provider and follow up accordingly with the Rural Health Clinic.

All Sharp injuries/ needle sticks need to be seen in the ED Dept

WORK RELATED INJURY PROCESS

This process must be completed within 24 hours of injury

Employee
Event/Injured at work

Complete 1st Report of Injury
(Intranet HR Site: Worker Comp Process)
Give document to Manager

Drug & Alcohol Test performed in Occupational Health in ER dept, ER staff as backup .

For medical care, make appointment at BCH Clinic (208)267-3655 x 4401

Use First Fill Pharmacy document for medication

Give Medical release form to Manager

Manager Completes Supervisor Accident Investigation document

All Documents turned into Human Resources

Emergent Care Only:
- Stroke
- Heart attack
- Major blood loss
- Loss of consciousness
- Broken bone
- Needle Stick
- Blood exposure
- Body fluids exposure

Go to BCH Emergency Department

BOUNDARY Community Hospital

Employee Injury or Illness Report

(To be completed by the employee)

Name:	Date of Birth:	Social Security # :	Hire Date:
Address:	Marital Status: ☐ Married ☐ Separated/Divorced ☐ Single	Occupation/Job Title: Employment Status: ☐ Full Time ☐ Variable	
Phone# :	# of Dependants:	Date Employer Notified:	

Date of Injury:	Time: ☐ AM ☐ PM	Did you complete your shift? ☐ Yes ☐ No	Time you began work: ☐ AM ☐ PM
Department/Location where injury/illness occurred?		Work process you were engaged in at the time of the injury/illness?	
Was this part of your body injured before? ☐ Yes ☐ No		Witness Name:	
Describe the occurrence: (The sequence of events leading to the injury and include any objects or substances that directly injured you):			
Describe the nature of the injury/illness and body parts affected:			
Employee Signature:		Date:	

(To be completed by Supervisor)

☐ Non-recordable First Aid (First aid treatment for minor injuries which do not ordinarily require medical attention event though first aid was provided by physician)
☐ Medical Treatment Care (Medical treatment includes treatment other than first aid administered by a physician)
☐ Hospitalized more than 24 hours
☐ Loss of workdays or restricted activity
☐ Future major medical anticipated
☐ Death
Supervisor's Remarks:

Supervisor's Signature:	Date:

(To be completed by Human Resources)

Physician/Health Care Provider:	Reviewed by Risk Manager:	Date:
	Reviewed by Safety Manager:	Date:

Occurrence resulting in: ☐ Illness ☐ Injury		Remarks:
Was activity restricted? ☐ Yes ☐ No	Number of Days: ☐ Actual ☐ Estimated	
Were work days missed? ☐ Yes ☐ No	Number of Days: ☐ Actual ☐ Estimated	
Reported to Worker's Compensation Carrier:		Date:

GET YOUR WORKERS' COMPENSATION PRESCRIPTIONS QUICKLY AND EASILY

SIF, Idaho Workers' Compensation has partnered with Optum to provide pharmacy benefits for your workers' compensation claim. Below is your First Fill card that will allow you to receive your initial injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured worker:

Fill your first work-related injury or illness prescription at any Optum Tmesys® partner pharmacy. Give this temporary card to the pharmacist. Your prescription will be filled with generic medications unless otherwise indicated by your physician. You will only receive your initial prescribed medication up to a 21 days' supply. In most cases, the pharmacy will fill the prescription at no cost to you.

Should your workers' compensation claim be accepted, you will receive a permanent pharmacy card in the mail. Once you receive your permanent pharmacy card you must present it at each fill to avoid being charged for your prescription.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to your injured worker.

OPTUM®

SIF, Idaho Workers' Compensation
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789. Tmesys is the designated PBM for this patient.

This Card is to be used on a one time basis and expires 24 hours from its use for the initial medications. Medications to be filled with a maximum of a 21 day supply. Mandatory generic substitution unless otherwise noted by physician. For further processing questions, including blocked transactions and prior authorizations, call 1-800-964-2531.

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	IDWCFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2113-23

BOUNDARY Community Hospital

Supervisor's Accident Investigation for Employee

(To be completed by the employee's supervisor or other responsible administrative personal)

Location where accident occurred	Employer's Premises: Yes ☐ No ☐	Date of accident or illness:
Who was injured?	☐ Employee ☐ Non-Employee	Time of accident: a.m. ☐ p.m. ☐
Length of time with facility	Job Title or occupation	Name of dept. normally assigned to:
What property/equipment was damaged?		Property/equipment owned by:
What was employee doing when injury/illness occurred?	What machine or tool was being used?	What type of operation?
How did injury/illness occur? List all objects and substances involved.		
Part of body affected/injured?	Any prior physical conditions? If so, what? Yes ☐ No ☐	
Nature and extent of injury/illness and property damaged (be specific)		

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

☐ Improper instruction	☐ Failure to lockout	☐ Unsafe arrangement or process
☐ Lack of training or skill	☐ Unsafe position	☐ Poor ventilation
☐ Operating without authority	☐ Improper dress	☐ Improper guarding
☐ Horseplay	☐ Improper protective equipment	☐ Improper maintenance
☐ Physical or mental impairment	☐ Unsafe equipment	☐ Inoperative safety device
☐ Failure to secure	☐ Poor housekeeping	☐ Other _____

Supervisor's corrective action to ensure this type of accident does not recur:

	Yes	No	N/A
Was employee trained in the appropriate use of Personal Protective Equipment/Proper Safety Procedures?	☐	☐	☐
Was employee cautioned for failure for use Personal Protective Equipment/Proper Safety Procedures?	☐	☐	☐
Did employee promptly report the injury/illness?	☐	☐	☐
Is there modified duty available?	☐	☐	☐

Supervisor's name	Supervisor's signature	Ext: #	Date